**INFLUENZA VACCINE 2020-2021 HEALTH SCREEN & PERMISSION FORM**

**School Name: CDS and Dedham**

**NPI:1649213125**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| \*Full Name: | | \*Date of Birth:  **/ /** | | | Age: | \*Gender: |  |
| \*Street Address: | | \*Town/City: | | | | \*Zip Code: | Daytime Phone: |
| Grade: | Teacher: | | | | | School Administrative Unit (District) CDS and Dedham schools | |
| \*Required  Is this person an American Indian or an Alaskan Native?  Is this person uninsured? | | | * yes * yes | * no * no |
| Is this person insured by MaineCare (Medicaid)? | | |  yes |  no |
| MaineCare ID #:  Private Insurance? | | |  yes |  no |

**Name of Insurance Company**:

**ID Number**: Group Number:

**Subscriber Name**: Subscriber Date of Birth:

Doctor’s Name: Phone Number:

**Please answer the following questions about the person named above.** Comments may be written on the back of this form.

**YES NO**

|  |  |  |
| --- | --- | --- |
| 1) Does this person have a severe (life-threatening) allergy to eggs? |  |  |
| 2) Has this person ever had a severe reaction to an influenza immunization in the past? |  |  |
| 3) Has this person ever been diagnosed with Guillain-Barre Syndrome? |  |  |
| 4) **(nasal flu)** Does this person have asthma or wheezing issues? |  |  |

**If you answered “yes” to any questions 1-3, please see your healthcare provider for influenza vaccination**

**PERMISSION TO VACCINATE**

* I was given a copy of the Influenza (Flu) Vaccine Information Statement, I have read this or had this explained to me and I understand the benefits and risks of the Influenza vaccine.
* I give permission for a record of this vaccination to be entered into the ImmPact Registry.
* I give permission for information to be used to bill MaineCare or private insurance for the cost of providing the vaccine
* I give my consent for this person to receive the most appropriate vaccine, as determined by the health care clinic staff.
* **I give permission for the flu vaccine to be given to the person named above by signing below.**

**Printed Name of Parent/Guardian or Adult:**

**X Date:**

**Signature of parent/guardian or adult to be vaccinated**

**FOR OFFICE USE ONLY:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date Dose Administered** | **Vaccine Manufacturer** | **Lot Number** | **Dose Volume** | **Signature and Title of Vaccinator** | **Body Site** | **Route** | **VIS date** |
| / / |  |  | 0.5 cc |  | LA  RA | * IM single dose * IM multi vial * Nasal | 8/15/2019 |
| State Supplied  Y N |

UMMS Provider Code: 116737176